From: Kristian, Diona (CMS/CMCS)
To: HHSC TX Medicaid Waivers; Montalbano,Kathi (HHSC); Bilse,Brittani (HHSC); Caruthers,Courtney (HHSC); Grady,Victoria C (HHSC); Young,Gary (HHSC); Nawab,Mohib (HHSC)
Cc: Greenfield, Eli S. (CMS/CMCS); Devoid, Isaac (CMS/CMCS); Blunt, Ford J. (CMS/CMCS); O"Malley, Kathleen (CMS/CMCS); Higgins, Shelby (CMS/CMCS); Marunycz, Lisa (CMS/CMCS); Garner, Angela D. (CMS/CMCS); Cash, Judith (CMS/CMCS); DeCaro, Teresa (CMS/CMCS); Rashid, Mehreen (CMS/CMCS); Howe, Rory (CMS/CMCS); Branch, Jeoffrey A. (CMS/CMCS); Badaracco, Andrew (CMS/CMCS); Ferguson, Dorothy A. (CMS/CMCS); Kimble, Davida R. (CMS/CMCS); Goldstein, Stuart S. (CMS/CMCS); Thompson, Christopher C. (CMS/CMCS); Mccullough, Francis T. (CMS/CMCS); Curry, Celestine J. (CMS/CMCS); Silanskis, Jeremy D. (CMS/CMCS)
Subject: RE: CMS Feedback on Attachment T
Date: Thursday, September 23, 2021 4:19:00 PM
Attachments: image001.png

Good Afternoon Texas Team,

Thank you for the recent submission and discussion regarding the cost reporting requirements for the Public Provider Charity Care Program (PHP-CCP).

In reviewing the submitted cost report, the terminology used was not consistent and created much of the confusion. After getting a better understanding from the call earlier this week CMS is now able to provide some guidance on refining the cost report.

CMS would seek to have the following items addressed to ensure the accuracy of the providers' costs and charges to develop an accurate total facility Cost-to-Charge Ratio (CCR), that can then be uniformly used to the applicable program (Medicaid/CHIP/Charity).

a. Cost Reports:
   i. Direct Cost – The state is required to limit the direct cost to the cost of providing direct services to patients in the facility (Salaries of direct care workers and supplies associated with the provision of direct care).

   ii. Indirect Cost – The state will need to develop a method to identify indirect costs (costs that serve more than one function within the facility, but are not costs directly related to the services being provided in the facility). The instructions for options to calculate the indirect cost rate are described in the instructions for the Section 223, CMHC cost report published here: https://www.medicaid.gov/medicaid/downloads/ccbhc-cost-report-instruction.pdf

   iii. Uniform Charge Master – In using cost to charge ratios, the provider must have a uniform charge master for all services performed at the facility – charges for services must be uniform for all individuals that come to the facility: charges for uninsured, Medicaid, Medicare, and Private insurance must all be the same.

   iv. Exhibit 1 – General & Statistical
   1. Item 1.06 Title Should be Changed to MCO Paid Claims, remove cost.
   2. Item 1.08 Why is this revenue amount entered as a negative number when all other receipts are a positive.
   3. Item 1.09 Title Should be changed to U/U Charges
   4. Item 1.13 – 1.15 Title should remove costs and replace with CHARGES
   5. Item 1.16 (OTHER) All grant/donation/appropriations/etc used to pay for direct medical services, reported as Charges to the extent not

already reported in 1.09.
    a. This differentiates from 1.15 as these items are not discussed in the Protocol
6. Addition Line needed: Grants/Donations/Appropriations applied to billed charges.
    a. We observe a reduction in the Exhibit 6; however, to the extent funds derived from other sources that are used for the direct medical services rendered and not otherwise accounted in 1.08 should be included in this line to fully realize all payment sources.

v. Allocation to Medicaid (CCR)–

1. In some circumstances, providers that have used cost-to-charge ratios to scale the provider's cost as it relates to the overall charges incurred by the facility. In the development of cost-to-charge ratio, the charges represent all services provided by the facility to all patients, regardless of payer within a given facility. Required elements for calculating & applying a cost-to-charge ratio in Medicaid:
    a. Total Facility Costs for Direct Medical Services (regardless of payer)
    b. Total Facility Charges (all payer including)
    c. Medicaid Charges
2. Exhibit 2 update formulas to ensure proper computing of CCR.
3. Exhibit 2: 2.20: Reductions: Additional refinement/instruction would be needed to account for all sources of revenue that would be attributed to the same period in which medical services were provided.
    a. The instructions point to Exhibit 6; however, Exhibit 6 in the Workbook is Payroll and Benefits and makes the assumption that only FTE are supported by other sources
4. Exhibit 2: 2.21: Amend to: To the extent amounts not entered in Exhibit 1.16 that are required to be reported
5. Further discussion needed to better understand Exhibit 8 – Schedule D. This appears to convert unreimbursed charges as costs in Column M; however, the information does not appear to flow anywhere in the Cost Report.

vi. Time Study – The cost report instructions, as submitted, do not account for the time employees spent providing direct care to individuals. Likewise, the personnel included in the cost report and instructions appear to include individuals who are not 100% dedicated to the provision of care and services for Medicaid beneficiaries. The time studies must be conducted either through paper (less effective) or electronically. State indicates daily timesheets, but the time studies must be statistically valid if this method is employed.

1. CMS can work with the State to develop a method that can be used in a short interim period while refining the final time study logistics.

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Sent: Friday, September 10, 2021 12:32 PM

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Subject: RE: CMS Feedback on Attachment T

Good morning Diona,

Please find HHSC's responses to the CMS Feedback on Attachment T and Cost Report along with supporting files attached.

HHSC would also like to ask CMS to provide specific details on both the payment protocol (Attachment T) and the Cost Report that CMS is needing modifications made to as well as requesting a call every week to work through issues to bring this to a resolution.

Sincerely,

Dawn M. Roland

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From: Kristian, Diona (CMS/CMCS) <Diona.Kristian@cms.hhs.gov>
Sent: Wednesday, September 1, 2021 1:57 PM
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Subject: CMS Feedback on Attachment T

Hello Texas Colleagues,

CMS has reviewed Attachment T, for Demonstration Year 11, and the associated Application Cost Report/Tool, as submitted on June 30, 2021. CMS has the following feedback on these documents.

1. CMS needs additional information on the roles and relationships of the entities the state intends to make the pool available to, with respect to local governments.

2. CMS understands that Texas intends for the eligible providers to provide the non-federal share for this pool via Certified Public Expenditures. However, 501(c)(3) are not Governmental entities and ineligible to participate in Certified Public Expenditure Per Social Security Act 1903(w)(6). Only the local unit of government that may have a contract with the 501(c)3 may claim certain costs of the contract as their expenditure as a CPE on a cost report to be used as State Share.

3. The state's intended cost report structure is inadequate for CPE-driven programs, and would require the following modifications to be approvable:
    a. Isolation of costs and revenues associated with providing care to Medicaid and uninsured populations, vs. other payers/self pay/funding from local governments/federal grants/etc.
    b. Adherence to the CMS method of time studies (with CMS review and approval of the

time study methodology)

c. Step down of time/effort to costs
d. CMS approval of the cost reporting methodology to determine the reimbursable costs.

If you would like to discuss our feedback, please let me know your availability and I will set up a call.

Thank you,
Diona Kristian